

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G098		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 03/28/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 10707 BERNADETTE DR EVANSVILLE, IN 47725			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{W 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a post certification revisit (PCR) to the investigation of complaint #IN00143237 completed on 2/14/14.</p> <p>This visit was in conjunction with the PCR to the recertification and state licensure survey completed on 11/8/13.</p> <p>Survey dates: March 24, 25, 26 and 28, 2014.</p> <p>Facility Number: 000637 Provider Number: 15G098 AIMS Number: 100234000</p> <p>Surveyor: Jo Anna Scott, QIDP.</p> <p>Community Alternatives SW IN was found to be in compliance with 42 CFR Part 483, Subpart I and 460 IAC 9 in regard to the PCR for the investigation of complaint #IN00143237.</p> <p>Quality review completed April 1, 2014 by Dotty Walton, QIDP.</p>			{W 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.